32.0.0 FAMILY CARE

32.1.0 Definition

The Family Care (FC) program is a long-term care benefit and a new way of delivering long-term care services in selected pilot counties. The counties currently operating the Family Care program are Fond du Lac, La Crosse, Portage, Milwaukee and Richland.

Family Care target groups are elderly people, people with physical disabilities and those with developmental disabilities. Counties can choose to cover any or all of those target populations during the pilot phase of the program.

32.2.0 Administration

Three groups work together to administer the Family Care program:

- A **Resource Center** (RC) serves as a "one-stop" shopping point to provide information and assistance in accessing available support services, housing, costs, and community services. Resource Center staff also assess potential clients' functional level of care, which is an eligibility criteria.

- **Economic Support Agencies** determine and certify Medicaid and Family Care non-financial and financial eligibility, and process Family Care enrollment.

- **Care Management Organizations** (CMOs) complete a comprehensive assessment and develop a plan of care, as well as provide and/or coordinate long term services for Family Care enrollees. Participants in the Family Care program choose to be enrolled in a CMO.

32.3.0 Family Care MA & Non- MA

There are two types of Family Care financial eligibility:

Family Care MA clients are eligible for MA services and receive a Forward Card. They have their long-term care needs met via a Family Care CMO. They may have a cost share or a spenddown. In CARES, their MA eligibility is represented by an open MA assistance group (which may include a community waivers AG) for example NS, MCWW, MAOR, etc. Enrollment in the Family Care CMO is represented by an open "FC" assistance group in CARES. Family Care MA participants have both an open MA and an open FC AG.

32.3.0 Family Care MA and Non-MA (cont.)

Family Care Non-MA participants are not eligible for MA (usually due to excess assets or income). They do not receive a Forward Card. However they are eligible to receive their long-term care services via a Family Care CMO. They have a cost share. In CARES, Family Care non-MA participants will show a closed or denied MA AG, and an open FC AG which represents their enrollment in the Family Care CMO.

32.4.0 Functional Eligibility

Resource Center staff use the Long Term Care Functional Screen to assess a Family Care applicant's long term care needs and to determine level of care. The functional level of care information is provided to the ES Worker so that s/he can determine eligibility for Family Care.

The levels of care are:

- Comprehensive Nursing Home (CNH),
- Comprehensive (COM),
- Intermediate (ICF), and
- Grandfather status for applicants who were receiving services from the county prior to the implementation of Family Care.

Use community waiver MA criteria to determine eligibility for clients with a Comprehensive Nursing Home (CNH) level of care. Determine eligibility for all other clients using EBD MA criteria.

32.5.0 Family Care Non-MA Eligibility Determination

Use Family Care Non-MA eligibility criteria if the applicant has failed eligibility for all other categories of full benefit MA. This includes those with unmet deductibles.

To be non-financially eligible, Family Care applicants must meet the EBD MA nonfinancial requirements with the following exceptions:

1. S/he must be 18 years of age or older.

2. S/he must be FC functionally eligible or meet the grandfather criteria.

The CMO network of providers must have the capacity to

32.5.1 Non-Financial Requirements (cont)

enroll the client and provide for his/her needs. The Resource Center worker gives this information to the ES worker.

4. S/he is not required to be determined disabled by the Disability Determination Bureau (DDB).
5. S/he must be a resident of the Family Care (FC) pilot county.

   Note: The client may be placed by the CMO outside of the county and maintain residency.

32.5.2 FC Non-MA Financial Eligibility Determination

Determination of FC Non-MA eligibility is a three-step process. The ES worker determines countable monthly asset and income amounts. The total of countable monthly assets and income is called the client's monthly resource amount. From this, calculate a monthly cost share.

There are no income or asset limits for Family Care Non-MA. An client is financially eligible if the monthly FC cost share is less than the projected monthly cost of the client's care plan at either the intermediate or comprehensive level. When determining initial eligibility, use a projected cost of care plan.

Use the Family Care Eligibility Non-MA Financial Determination worksheet (WKST 12) to determine eligibility.

32.5.2.1 FC Non-MA Net Countable Asset Determination

1. Determine the client's monthly net countable assets using EBD rules and MAHB Appendixes 11.0.0 and 23.0.0. Count the assets of both the client and spouse if the client is legally married. If both spouses are applying, do calculations for each individually. Do not include Independence Accounts, or interest generated from these accounts.
2. From the total countable assets, deduct the following:

   a. The Community Spouse Asset Share (CSAS), if applicable (23.6.0). If both spouses are being tested for FC/Non-MA, allow the CSAS for each spouse separately.

   b. A Family Care basic asset allowance:

32.5.2.1 FC Non-MA Net Countable Asset Determination (cont.)

- If the client lives in a nursing home (NH), Community Based Residential Facility (CBRF), or Adult Family Home (AFH), disregard the Basic Asset Allowance (30.12.0).

- If the client lives in a private residence, a Residential Care Apartment Complex (RCAC) or other community setting, disregard the Basic Asset Allowance (30.12.0).

3. Divide the remainder by twelve. The result is the monthly net countable assets of the client.

32.5.2.2 FC Non-MA Income Determination

1. Determine the client's monthly earned income. Count any unemployment or worker's compensation payments as earned income for Family Care Non-MA.
2. Deduct $200 and 2/3 of the earned income from the client's monthly earnings. This is the adjusted earned income.
3. Determine unearned income using EBD rules (15.0.0).
4. Add the adjusted earned and unearned income together.
5. Deduct $20 from the combined income. The total is the client's countable monthly net income.

32.5.2.3 FC Non-MA Cost Share

1. Add the client's countable monthly net asset and countable monthly net income amounts. The total is the countable monthly resource amount.
2. From the total countable monthly resource amount, deduct the following, if applicable:

- Community Spouse income allocation amount (23.6.0).

- Court ordered payments (15.3.2.1).

- Basic needs allowance. The amount is based on the client's living arrangement:

    a. Basic needs allowance (30.12.0) if s/he lives in a Nursing Home, Adult Family Home or Community Based Residential Facility, **or**

32.5.2.3 FC Non-MA Cost Share (cont.)

b. If the person lives in his/her own home or other community setting, the client receives the greater of the SSI Payment Level Plus the E Supplement (30.5.0) for one person or actual maintenance costs up to the EBD Maximum Personal Maintenance Allowance (30.5.1). Actual maintenance costs consist of shelter costs (rent, mortgage, taxes, insurance, condo fees, standard utility allowance, food stamp allotment for one person, and standard clothing allowance of $100 per month).

- Home maintenance costs up to the SSI Payment Level Plus the E Supplement (30.5.0), if living in a medical institution but expected to return home within six months (15.3.1).
- Out of pocket medical/remedial expenses (15.3.3).
- Dependent family member income allocation amount (23.6.0).
- Health insurance monthly premium amount (25.9.2.4).

The total countable monthly resource amount minus applicable deductions equals the monthly cost share amount.

To determine eligibility, compare the cost share amount to the cost of a Family Care projected plan of care for the functional level assigned to the client. The projected cost of care for clients is listed in 30.12.0.

If the cost share is less than the cost of the projected care plan, the client is eligible for Family Care Non-MA and must pay the determined cost share amount monthly.

If the cost share is greater than the projected plan of care, the client is not eligible for Family Care. However, the person may choose to purchase an assessment from the CMO to develop an actual care plan. If the cost of the actual care plan is greater than the person's cost share amount, the person is eligible for Family Care Non-MA. Use the actual care plan costs from the CMO in subsequent eligibility tests.

32.6.0 Enrollments, Disenrollments and Intercounty Moves

The enrollment date is always the date that the client is enrolled in the CMO. The Resource Center worker provides the ES worker with this information.

32.6.1 Enrollments

32.6.1.1 Urgent Services

Determine Family Care eligibility for a person who received urgent services as of the date the CMO began providing services. The CMO is paid the capitated rate as of that date, if the person is found eligible and chooses to enroll.

If the person is found ineligible for Family Care, the CMO bills the client for the care and urgent services it provided.

32.6.1.2 SSI Recipients

A full MA application or review is not necessary for an SSI recipient who asks to enroll in Family Care, and is not applying for Food Stamps. The RC worker will supply the ES worker with the following information:

- Name.
- Residence Address.
- Mailing Address.
- SSN (and MAID number if different).
- Sex.
- Primary Language (English or Spanish).
- Guardian/Power of Attorney Name and Address.
- Date of Birth.
- Race (Optional)
- Citizenship Status (Alien registration number, if not a citizen).
- Disability Status (if not age 65 or older).
- All information necessary to complete screens ANCW, AFME, ANMC and ANFR.

They may use the “Model Agency Referral Form” to provide this information. Workers can contact clients as needed for additional information.

32.6.2 Disenrollment

32.6.2.1 Adverse Action Dienrollment

CARES populates the date when there is ineligibility for FC. It is not worker enterable. The date will be an end of month date according to adverse action logic, except when the client dies. In this case, the The disenrollment date is the date of death.

32.6.2.2 Voluntary Disenrollment

If a client asks to disenroll prior to the date set according to adverse action logic, fax the paper disenrollment form to the DHCF Enrollment Specialist at (608) 261-7793. The request will then be forwarded to EDS for entry in MMIS.

32.6.3 Inter-county Moves

When a FC enrollee moves permanently to a non-CMO county, s/he can remain enrolled in the CMO only if the Resource Center worker informs ES that the following four conditions are met:

1. S/he is eligible for COP or waiver services.

2. After moving to the new county, the enrollee resides in a long-term care facility (Nursing Home, CBRF, or AFH).

3. The enrollee's placement in the long-term care facility is done under and pursuant to a plan of care approved by the CMO.

4. The enrollee resided in the CMO county for at least six months prior to the date on which s/he moved to the non-CMO county.

32.7.0 Closures

If a FC case closes for any reason and re-opens without a new application, contact the CMO to determine if the client has been served continuously by the CMO. Note in case comments any information from the CMO.

If the client has been served continuously by the CMO, do not complete a new enrollment form. If a disenrollment date exists on ANFR, begin another segment with a start date for the day following the disenrollment date.

If the client has not been served continuously by the CMO, a new enrollment form signed by the client, and enrollment date are required.